Study on the Access to Health Services by Domestic Violence Victims in Maldives

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Abbreviations

CEDAW	Convention on Elimination of All Forms of Discrimination against Women (CEDAW)
DV	Domestic Violence
DVP Act	Domestic Violence Prevention Act
DVPNS	Domestic Violence Prevention National Strategy
ER	Emergency Room
FCPD	Family and Child Protection Department
FCSCs	Family and Children Service Centers
FPA	Family Protection Authority
GBV	Gender Based Violence
HPA	Health Protection Agency
HRCM	Human Rights Commission of Maldives
IGMH	Indira Gandhi Memorial Hospital
MoH	Ministry of Health
MoLG	Ministry of Law and Gender
NGO	Non- Government Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAC	Violence Against Children
VAW	Violence Against Women

I. Introduction

1.1. Objectives

The study provides a synopsis and recommendations on the institutional situation around the access by domestic violence victims to health services in Maldives.

1.2. Methodology

A desk review of existing analyses and regulations constituted the first phase (February - March 2017) of the study. Semi-structured interviews with key informants were held in April – August 2017.

1.3. Limitations

While representatives from the Health Protection Agency (HPA), Family Protection Unit (FPU), Family and Child Protection Department (FCPD), Family Protection Authority (FPA), Ministry of Gender and Family (MoGF), civil society and international organizations were interviewed, the report would have benefitted from insights by other key stakeholders, such as judicial sector, and survivors of domestic violence.

The absence of a joint statistical database on domestic violence (DV) and confidentiality obligations of institutions that collect this data, did not allow for a detailed quantitative analysis. The report largely focuses on women-victims of domestic violence, without specifically analyzing other groups, such as children, migrant workers and elderly.

The research was conducted in Malé City, which presents a gap in terms of the direct observation of the situation in outer atolls.

II. Context

Many had believed that domestic violence in Maldives was rare or non-existent[1], until the first ever national representative survey on violence against women (VAW) was published in 2007. The survey found that at least 1 in 3 women aged 15-49 had experienced some form of physical and/or sexual abuse during their lifetime, among which 1 in 5 reported that they had experienced physical or sexual violence, or both, by an intimate partner[2].

As a signatory to the Convention on Elimination of All Forms of Discrimination against Women (CEDAW) and basing on the gender equality principle stated in the Constitution, in April 2012 the People's Majlis (Parliament of Maldives) passed the Domestic Violence Bill (hereafter referred as Domestic Violence Prevention

[1] See in Fulu, E. (2014) Domestic Violence in Asia: Globalization, Gender and Islam in Maldives.
[2] The Maldives Study on Women's Health and Life Experiences, 2007.

(DVP) Act). Under the DVP Act "domestic violence" shall mean any of the acts [list of 17] by a perpetrator where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the victim(s), and provided the victim(s) and perpetrator are in a domestic relationship"[3].

Given the fact that DV victims would most probably seek medical support in the first instance, the DVP Act described the roles and responsibilities of health care providers (HCP) at personal and professional levels[4], besides others. Moreover, administrative sectors, such as Ministry of Health, Health Protection Agency and institution in the Justice Sector were given responsibility to provide adequate facilities and training and strengthen the relevant areas of care provision.

In the aftermath of the DVP Act adoption, the government developed a number of sectoral plans and strategies to support the implementation of the law,[5] including the first ever Maldives Domestic Violence Prevention National Strategy 2014-2016 (DVPNS 2014-2016). With support by the United Nations Population Fund (UNFPA), in 2014 the Health Protection Agency issued a guideline titled "Health sector response to GBV: national guideline on providing care and prevention for health care providers" (hereafter referred as the Guideline), and an online training module for HCPs was developed.

However, human rights activists state that there is little political will to work on DV issues. Through such reporting mechanisms as CEDAW Shadow Report, civil society activists alert the international community on the issues existing in the area of DVP Act implementation. The January 2015 CEDAW Shadow Report stated, for instance, that "the main issues faced in protecting victims of domestic violence include absence of requisite procedures, inconsistencies in institutional applications, lack of sensitivity among law enforcement, judiciary, health and social service providers towards DV. It is also important to emphasize the common belief amongst law enforcement and judiciary that DV cases are family matters, which negatively impact victims from getting redress"[6]. Domestic violence in Maldives is, hence, at the line between individual concerns and being a health care issue that is not recognized as such by many state authorities.

The Maldives Domestic Violence Prevention Strategic Plan 2017 – 2021, developed to replace the DVPNS 2014 – 2016, provides a brief analysis of the context in the area of DV. As for the health services, the Plan notes, in particular, that there is "a general issue with access to health, law enforcement and justice that impedes effective domestic violence prevention mechanisms. Mental health and psychological health are underdeveloped areas in general and affect domestic violence policy and practices"[7].

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[3] Domestic Violence Act, #3/2012, unofficial translation by UNFPA.

[4] See Annex 1.

[5] See in Health Sector Response to GBV. National Guideline on Providing Care and Prevention for Health Care Providers. UNFPA and HPA. 2014, p.28.

[6] Submission from Human Rights Commission of the Maldives for the combined Fourth and Fifth Periodic Report of the Republic of Maldives to the United Nations Convention on Elimination of All Forms of Discrimination against Women (CEDAW) Committee January 2015.

[7] Maldives Domestic Violence Prevention Strategic Plan 2017 – 2021, Appendix A.

While there have been explicit articles[8] on DV issues in general and on its specific aspects[9], there is a need to look at the current state of health care provision for DV victims. This would allow for development of recommendations, taking into account best practices existing in other countries, for actors involved into DVP Act implementation. The following synopsis is structured around the guiding principles described in the National Guideline on Providing Care and Prevention for Health Care Providers and is mostly based on respondents' insights and opinions, and relevant documents.

III. Provision of Health Care for Victims of Domestic Violence

3.1. Services available and minimal standards

While the Guideline provides a list of minimum medical, psychological, medico legal services and referrals to be available for a victim[10] at the level of health posts, atoll-, regional-, and tertiary care hospitals, it is evident from the analyses and interviews that there is a significant disparity between Malé and islands in this regard.

The 2015 CEDAW Shadow Report, in its Health Article states the following: "Although there are regional hospitals and healthcare centres throughout Maldives, basic health services including sexual and reproductive health services are not fully and easily accessible to people living in the atolls. Hospitals/Health centres in the atolls lack healthcare equipment and professionals including gynecologists and gynecology equipment and devices". As noted in an interview, if even the Family Protection Unit (FPU) – the only medical referral service in Maldives, does not get referrals from other specialists, especially, psychologists, the situation in other hospitals and health posts must be ever more drastic. Furthermore, another interviewee noted that the need for psychological therapy must be identified by a doctor, and despite the fact that such services are covered by medical insurance, most doctors do not consider them necessary, as mental health is not yet high on the health bodies' agenda.

Minimum standards for health care services provision for DV victim, include the following, as per the Guideline: 1) location, furniture and setting; 2) skilled health care providers; 3) medications; 4) minimum medico legal services.

As for the first, it appears that standards existing, for instance, even in FPU, do not correspond to the required minimum. As noted in one of interviews, FPU's location at the Indira Gandhi Memorial Hospital (IGMH) and the fact that patients can only access it through ER, presents considerable challenges in DVP Act

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[8] See, for instance, Abdulghafoor, H. *Violence in the Maldivian family. Why does it continue to breed despite the Domestic Violence Prevention Act?,* 23 April 2016, accessed at http://www.dhivehisitee.com/people/violence-in-the-maldivian-family-why-does-it-continue-to-breed-despite-the-domestic-violence-prevention-act/

[9] Hope for Women commissioned a number of internal analyses, for instance.

[10] See Annex 2.

implementation. Throughout its existence the Unit often lacked permanent space and could not provide safe and child-friendly environment for DV victims. The overall shortage of doctors and limited space, in addition to all victims' traumas, add to worsening of their psychological state, as they often have to visit the hospital many days in a row and wait for long hours.

Second, understanding and acting in accordance with the DVP Act is often challenging for the doctors. The Emergency Room (where the FPU is located) at IGMH has 30 staff, with high doctor rotation level being considerable disadvantage. All incoming ER doctors receive 2-weeks induction training that includes explanation of DVP Act obligations for the health sector. According to an interview, the abovementioned online GBV training for health care providers in IGMH occurred only once. In addition, while many DV victims come for obstetrics and gynaecology consultations, the doctors from respective department are not accountable to the FPU and, therefore, it is not clear whether they have been sensitized on DVP Act.

The online training on GBV, having been developed in 2015, after some time had difficulties with online domain and was later secured at the Health Protection Agency's IT department. The training's completion rate by doctors from other health units is overseen by the Health Protection Agency's (HPA) HR department that generates password and login for new expat doctors. The latter have to complete the course within their first 3 months in Maldives. It is difficult to estimate the number of doctors who completed the course, due to the fact that many of doctors work in private clinics. Besides IGMH doctors, ADK hospital was advised by HPA to make it obligatory for its medical personnel.

Third, while it was not possible to draw conclusions from the interviews on the minimum standards with regard to medications, the 2016 Action Plan for Health Sector Response: "Addressing GBV, Including DV in Maldives", notes the issue of emergency contraception ("morning after pill") not being available at island level health centers. As a solution, the plan suggests that arrangements should be made to obtain this medication in such an event without any delay[11], however, it is challenging to obtain data on the adherence to the plan and frequency of the use of this solution.

Fourth, interviews also reveal that while, by law, doctors are still compelled to fill in the medico legal form (MLF) in case of victim's hesitation, for many of them it often presents a personal conflict in terms of doctor-patient confidentiality (see also the section below), and some doctors, according to an interviewee, requested that the MLF reporting becomes optional.

Overall, the abovementioned disparity between the capital and outer atolls exists with regard to the standards, as well: scarcity of doctors, prevailing non-reporting of cases due to doctor's personal religious and cultural beliefs, long travelling distance from distant islands to regional and capital hospitals.

[11] Health Protection Agency. Action Plan for Health Sector Response: Addressing Gender-based Violence, Including Domestic Violence in Maldives, 15 May 2016, p.15.

3.2. Guiding principles: human rights and ethics

The Guideline lists the following human rights and ethical principles the HCPs have to adhere to when receiving a DV victim: 1) confidentiality and privacy; 2) safety; 3) being non-judgmental/ non-discriminatory; 4) respect.

As noted in the 2015 CEDAW Shadow Report, "information gathered from HRCM's atoll monitoring visits revealed that there have been many incidents where sensitive medical information of patients were leaked from the health centre. As a result, many women do not trust health facilities and their service providers, especially in the islands where small communities live"[12]. An interviewee from a service provider institution noted, however, that in the event of a victim's complaint on inappropriate behavior or action by the institution's employee, the matter is considered at the department of human resources; and if there is an apparent conflict of interest between a victim and an employee, the latter is exempted from handing the case which is then transferred to other staff. Nevertheless, other interviews revealed that most of women who come to the ER and are apparent DV victims do not want their case to be recorded and, worst, known by authorities. Interviewees also noted that in some cases where doctor was suspecting a patient might be a domestic violence victim, the doctor was threatened (including with death threats) by the patient's spouse, when asked to leave the consultation room.

The issue of safety appears to be an alarming one, as interviewees mentioned only one safe house for GBV victims existing in Villingili (part of capital agglomeration), whereas the CEDAW state Report mentions safe houses established in 4 atolls and Malé. Doctors feel powerless, knowing about the existence of the only one safe house in the capital atoll, where safety of a victim is not guaranteed due to the fact that the house's location is not kept secret by the police, and perpetrators may easily find it. Temporary nature of the shelter (maximum stay period is 3 months) does not allow for sufficient recovery of a victim and her/his reintegration into the society. In addition, the abovementioned issue with FPU's premises, for instance, and the fact that it is challenging to receive patients in a secure environment, add to the problem.

Many interviews supported the fact that in many cases, especially in outer atolls and small communities, doctors find it difficult to remain non-judgmental and respect individuality of a victim. Interviewees noted, as well, that while there are mostly no commitment issues among doctors based in Malé, those in outer atolls are less sensitized. Being judgmental is often linked to personal religious and cultural beliefs, social norms and bias existing in a community. There are also indications of existing police inaction: police is aware in most cases about DV and is responsible for bringing DV victims to hospitals when needed, although the question remains on the number of times it has actually occurred so, as many

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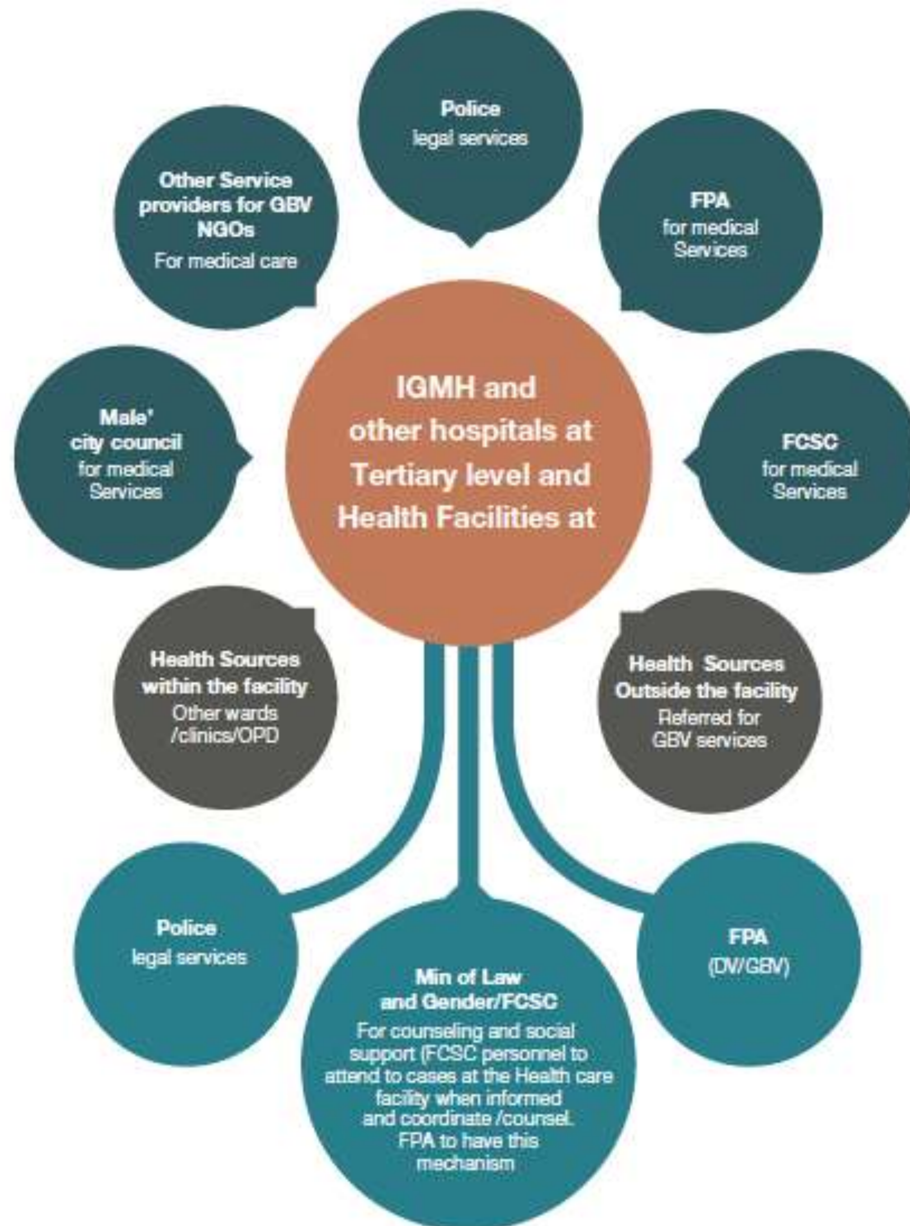
[12] Submission from Human Rights Commission of the Maldives for the combined Fourth and Fifth Periodic Report of the Republic of Maldives to the United Nations Convention on Elimination of All Forms of Discrimination against Women (CEDAW) Committee, January 2015, p.26.

police officers perceive DV as an internal family matter where nobody can interfere.

3.3. Referral pathways

The Guideline presents an explicit description of referral pathways:



As one can see from the figure above, health care providers are placed at the centre of referral scheme, with FPU to play the leading role. The Unit helps link a victim with other responsible parties.

Despite this explicit scheme of referral pathways, a number of interviewees noted that the latter are not fully functional. While there are known and well-documented referrals between FPU and other stakeholders in Malé, skills and commitment at island-level health posts, within local councils and police, are not adequate for providing explicit information and support to a victim. As one

interviewee stated, there is no monitoring body within the health sector to oversee referral mechanism and coordinate with other stakeholders. Whereas FPA conducts selected case monitoring to expedite services to victims referred by the MoGF, the latter has a certain criteria to identify the victim(s), and it is not clear if other stakeholders are aware of the selection procedure. In addition, another interviewee noted that there should be separate guidelines for police and the MoGF, and more clarity about each actor's role. This is supported by another statement describing the fact that the Ministry sometimes refers victims to non-government organizations, especially for psychosocial support, however, this type of cooperation is not formalized. To address the abovementioned issues, it was mentioned that there are ongoing discussions on expanding referral mechanism to include, for instance, the Maldives National Defence Force, and get increased commitment from more health facilities, especially private clinics.

3.4. Perpetrator

As noted in the Maldives Domestic Violence Prevention Strategic Plan 2017– 2021, the most underachieved area of the previous strategy is the work with the perpetrators. Perpetrator rehabilitation programme does not exist, despite some attempts by the FPA and some mediation cases by the MoGF. Moreover, as a subject to DVP Act, a perpetrator must be provided with psychological counseling, although the key informants could not recall that this had been done since the adoption of the Act. This also relates to the fact that it is up to the court to declare someone a perpetrator. Given the fact that there are only a handful of such cases and perpetrators are often in denial of the harm their actions caused and reject any assistance, it is challenging to develop a respective rehabilitation programme. There is also a lack of trained personnel in this area and non-clarity about division of responsibilities among stakeholders.

Though not directly linked to perpetrator rehabilitation, but related to the scale of the issue, - interviewees noted high rate of withdrawal of cases, due to the fact that victims would not have family and financial support in case if the family only has one breadwinner (who is often also the perpetrator).

IV. Building Linkages and Collaborating with Other Stakeholders

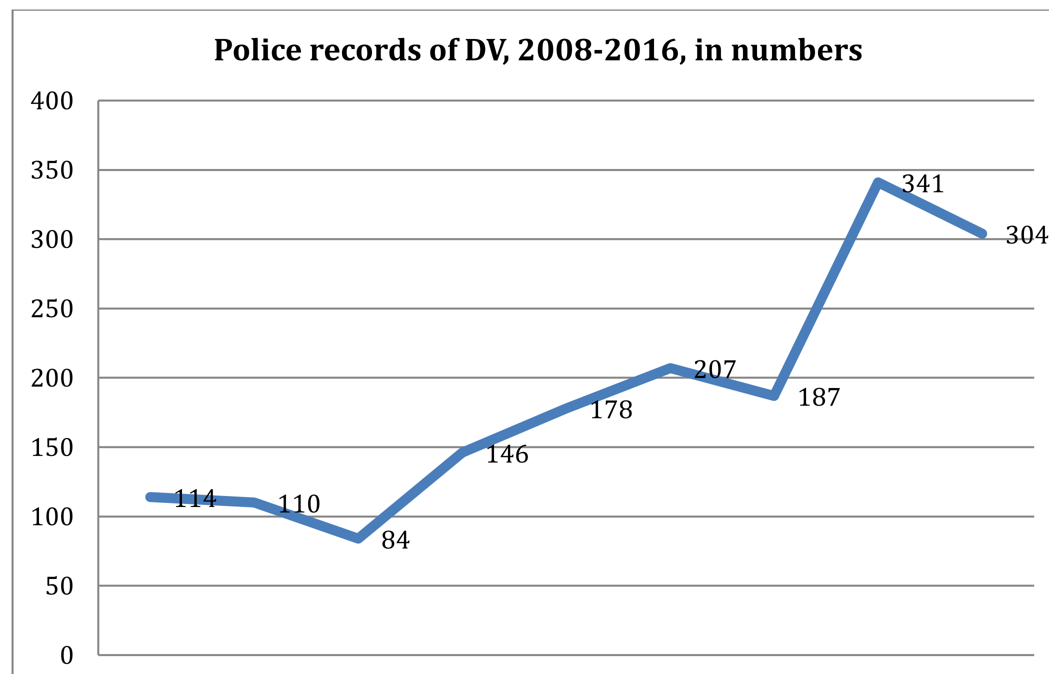
Linkages, cooperation among stakeholders, and partnerships are indispensable for an efficient implementation of the DVP Act. The coordination, as noted in the Maldives Domestic Violence Prevention Strategic Plan 2017–2021, "remains fragmented and can be improved significantly". While at one of the interviews it was noted that one successful area of the DVP Act is the information sharing between FPA and other stakeholders, that there are good relations, and real-time information and coordination, it appears that these mostly occur in Malé and their efficiency is not supported by evidence. Many argue that there is a high time domestic violence coordination forum, chaired by a senior government official, with clear annual work plans and schedule of meetings, established.

4.1. Data collection and information sharing among stakeholders

The absence of streamlined data collection from atolls, private and many public clinics, does not allow for an estimation of total number of DV victims in the country. The medico legal form allows for disaggregation of GBV cases into at least the following areas: 1) mental; 2) neglect; 3) out of wedlock pregnancy; 4) rape; 5) sexual abuse; 6) physical abuse. However, due to limited number of qualified medical staff and lack of refresher training, this disaggregation may not be fully representative. It is also believed that while the DV reporting has increased, there is no sufficient action being undertaken or there are very minimal efforts to address the situation.

The most recent Demographic and Health Survey (DHS 2009) has data on attitudes towards wife beating, refusing sexual intercourse with husband, men's attitude towards a husband's rights when his wife refuses to have sexual intercourse, which are proxy indicators for domestic violence, however, new data is required to see the trends in this area and develop policies. The long awaited new DHS should have been started in 2015 and there is funding is available, however, according to an interviewee, there is a lack of skilled researchers.

Interestingly, the website of Maldives Police Service provides statistical data on the number of DV offenses from 2008 to 2017[13]. It can be seen from the below chart that there is a growth trend in DV offenses. Although not indicated in the chart, 2017 number has reached 145 by the end of June, and if it doubles by the end of the year, the number of cases may reach 300.



As for other actors, FCPD has a dedicated data analyst who generates reports for the Ministry of Health and FPA. While it is known that the Ministry investigates

[13] See https://www.police.gov.mv/

the cases, FCPD is not aware of the follow-up on its data analysis reports. As for the age and social status of victims received by FCPD, most of them are married, followed by the unmarried and middle-aged women.

The interviewees noted that among all actors working on DV issue, MoGF infrastructure and presence in most of the islands offers best opportunity to collect data and conduct research, although the Ministry does not make full use of it. The FPA looks into data availability directly and ensures oversight, however, it has difficulties with streamlining data collection.

4.2. Awareness raising activities

According to interviewees, while population is in general aware of domestic violence, more activities are needed on the information about the DVP Act and remedies. Most of interviewed stakeholders are personally involved into national DV prevention advocacy campaigns, contribution to consultations, seminars, and knowledge sharing (e.g. DV brochures content), and in building capacity of islands' actors (e.g. by conducting teleconferences on the proper use of the MLF). In terms of advocacy, FPA has a 5-year advocacy plan, although there is a limited number of staff to implement it. While the Ministries of Education and Health organize awareness sessions in schools, the whole government should take responsibility to share such knowledge and improve their respective tasks with regard to the law and its implementation.

V. Recommendations

As can be seen from the government strategies and plans existing in DV area in Maldives, there is an assessment of the previous activities and objectives to work on gap issues. Best global practices[14] in preventing and responding to domestic violence cross-link to a number of areas that have already been planned for Maldives. The table below provides linkages between both and suggests intervention paths for civil society actors who can play an ever more active role in DV prevention and response.

Global practice	**Domestic Violence Prevention Strategic Plan 2017 – 2021 Goals**	**Intervention paths for civil society**
Comprehensive response to domestic violence including the provision of	- Ensure that Maldives domestic violence policy remains prevention focused and that all	- Continuous and more inclusive activism (e.g. involving religious leaders, youth),

[14] See, for instance, in Girardi, J. (2012) An Overview of International Experience and Best Practices in 5 Countries on Selected Aspects of Addressing Domestic Violence.

psychological, social, medical, legal support to survivors and establishment of a referral system within the context of intersectoral collaboration and existing legislative environment	relevant organizations proactively address the root-causes of domestic violence (prevention goal) - Use a partnership based approach to achieve effectiveness and efficiency (partnership goal) - Ensure that all stakeholder agencies are held responsible and accountable for their action/inaction on matters related to domestic violence (accountability goal) - Build capacity and upskill staff from FPA in key responsibilities (governance goal) - Build capacity of relevant organizations by providing them with training opportunities (governance goal)	campaigning, awareness raising and advocacy for policy development - Networking and collaboration: organizing widely inclusive fora with participation of a maximum number of stakeholders (ideally, co-organized with ministry-level partners); attracting more service providers (especially working on psychosocial isseus) from NGO sector
Development and operation of clients registration databases on domestic violence	Research and publish data on domestic violence in the Maldives (governance goal)	- Continue researching and sharing knowledge. If data is not available, look at proxy indicators (e.g. number of femicides) and monitor media - Continue working with local communities and empower them to tackle DV at island level
Development and application of assistance provision standards for		- Advocate for and offer inclusion of civil society experts in development

domestic violence survivors		of government strategies and plans
Domestic violence shelter management with specific attention to existing shelter regulations, models and standards of operation, funding mechanisms	- Ensure that all survivors who contact designated institutions receive appropriate level of protection and support that they need (protection goal): develop a robust regulatory mechanism to oversee the operation and services of all domestic violence service providers which include domestic violence shelters and other social service providing centers established throughout the Maldives	- Maintain free legal aid and look into a possibility of providing helpline service - Mobilize donor and government funds for shelter maintenance and opening of safe houses. Look into a possibility of NGO-run and protected by religious institutions shelters
Models of working with male domestic violence perpetrators, with specific best practices, standards and lessons learned	All perpetrators are held accountable to their action (accountability goal)	- Look into an opportunity of involving more men and/or supporting of establishment of a men-led NGO committed to the idea of "men against violence" - Mobilize funds and provide free psychological and family counseling aid

VI. References

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VII. Appendices

Annex 1: Roles and Responsibilities of HCPs as identified in DVP Act

Section 8.a. on reporting mentions that "Cases of alleged domestic violence pursuant to Section 8 a) may be reported by any of the following persons: Employee of a health or social service provider ..."

Section 9. on health care mentions that "A duty of care is hereby established on health professionals and social workers to report suspected cases of domestic violence ... Health professionals and social workers shall further provide full support during the investigative and court stages ..."

Section 12. mentions that "A health professional that has been notified by the Police that an act of domestic violence may have been committed on a survivor...must carry-out the following:-

1. Examine the suspected survivor to the highest possible degree...
2. Assist the survivor in seeking psychiatric or counselling support...
3. Prepare a written report based on the examination of
4. Submit the report prepared under Section 12(d) (2) to the Police and Authority"

While accepting that the Act defines the roles and responsibilities of the health care providers it must be mentioned that it is the responsibility of the administrative sectors such as Health Ministry, Health Protection Authority and Justice Ministry to provide adequate facilities and training and strengthen the relevant areas of care provision in order to ensure satisfactory implementation of the Act.

Source: National Guideline, part 3.3

Annex 2: Minimum services available

Services Medical services	Health Centers/ Health Posts	Atoll Hospitals	Regional hospitals	Tertiary Care Hospitals
Receive the survivor in a dignified manner	x	x	X	X
Provide empathetic listening and counseling	x	x	X	X
Take a history & basic clinical examination	x	x	X	X
Conduct relevant examination	x	x	X	X
Conduct specialized examination and in-depth investigations			X	X
Take sample for DNA Examination to send Forensic Services at police		x	X	X
Manage minor injuries	x	x	X	X
Manage possible major injuries including surgical interventions		x	X	X
Provide Emergency contraception immediately /on selected sites	x	x	X	X
Provide tetanus prophylaxis	x	x	X	X
Provide STI Prophylaxis	x	x	X	X
Provide HIV Prophylaxis (PEP)	x	x	X	X
Psychosocial Services				
Establish a good rapport with the survivor	X	X	X	X
Reduce anxiety and make her / him comfortable	X	X	X	X
Provide empathetic listening	X	X	X	X
Provide basic counseling	x	x	X	X
Referral for other services	x	x	X	X
follow up if required	x	x	X	X
Medico legal services				
Document history and examination for medico legal perspective	x	x	X	X
Collect samples for relevant laboratory examinations	x*	x	X	X
Complete medico legal forms and submit to relevant authorities	x	x	x	X

Provide Medical expert opinion in legal cases		x	x	X
Referrals and Linkages				
Referrals to a higher level health care institution(if needed)	x	x	x	X
Referral to Police Action	x	x	x	X
Notify aggregated report to FPA	x	x	x	X
Provide information on legal redress available .such as the health sector response in line with the Domestic Violence Act 2012	x	x	x	X

Source: National Guideline 3.4.1